DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-13	2. STATE: TEXAS
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: September 1, 2003	

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 04 $ 2,151,309 b. FFY 05 $ 25,516,30
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:

This amendment modifies the reimbursement methodology for nursing facilities (NFs) related to the cost finding methodology to describe current cost-related components; the rate setting methodology to accommodate changes related to the enhanced direct care staff rate and to allow adjustments to rates effective September 1, 2003 and September 1, 2004 necessary to remain within appropriations; and the enhanced direct care staff rate to come into compliance with recent legislative direction and to clarify and simplify procedures and language.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL: Jason Cooke by Bridget Bone	16. RETURN TO: **Jason Cooke** **State Medicaid/CHIP Director** **Post Office Box 13247** **Austin, Texas 78711**
13. TYPED NAME: **Jason Cooke**	
14. TITLE: **State Medicaid/CHIP Director**	
15. DATE SUBMITTED: September 19, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 22 2003	18. DATE APPROVED: FEB 17 2004
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP -1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: Brenda Smith
21. TYPED NAME: Charlene Brown	22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA – 179 (07-92)

III. Cost Finding Methodology. HHSC adjusts reported expense data using a cost finding methodology to determine per diem allowed costs. HHSC makes certain adjustments to ensure that costs used for rate projections are required for long term care, derived from the marketplace, and incurred from economic and efficient use of resources.

A. Cost determination by cost area. HHSC combines adjusted expenses (A.1. through A.4. below) and other pertinent data (A.5. below) from the rate base to determine five cost-related components.

1. Direct Care Staff cost component. The direct care staff cost component includes compensation for employee and contract labor Registered Nurses, Licensed Vocational Nurses, Medication Aides and Certified Nurse Aides performing nursing-related duties for Medicaid-contracted beds.
2. Other Recipient Care cost component. The other recipient care cost component includes compensation costs for social workers, activities staff, direct care staff trainers, therapists, pharmacists, medical directors and other direct care consultants, as well as costs for medical equipment and supplies, and laundry/housekeeping equipment and supplies.
3. Dietary cost component. The dietary cost component includes compensation costs for dietary staff as well as costs for food, ancillary nutritional therapy supplements, dietary equipment, and dietary supplies.
4. General and Administration cost component. The general and administration cost component includes compensation costs for administrative and maintenance staff as well as costs for management, legal and other consulting fees, property and equipment repair and maintenance, office supplies and equipment, insurance (excluding liability insurance), property taxes, transportation, and working capital interest.
5. Fixed Capital Asset component. Fixed capital charges are based on the most recent appraised value of facilities, including land and improvements, as determined by the most recent assessment of the local taxing authority and reported on the cost report. Tax exempt facilities not provided an appraisal from their local taxing authority because of an exempt status must contract with an independent appraiser to appraise the facility land and improvements.

B. Exclusion of Certain Reported Expenses. Providers are responsible for eliminating all unallowable expenses from the cost report. HHSC reserves the right to exclude any unallowable expenses from the cost report and to exclude entire cost reports from the data base if it is believed that the cost reports do not reflect economic and efficient use of resources.

1. Fixed Capital Asset Charges. Effective September 1, 1990, fixed capital asset costs are reimbursed in the form of a Use Fee calculated as described under section (IV)(B)(1). Consequently, the following fixed capital asset charges are excluded from the rate base for purposes of calculating the General and Administration cost component: building and building equipment depreciation and lease expense; mortgage interest; land improvement depreciation; and leasehold improvement amortization.

(4) Total case mix per diem rates. Total case mix per diem rates vary according to case mix class of service and according to participant status in the Enhanced Direct Care Staff Rate described in (VI).

(a) For each participating facility, for each of the 11 TILE case mix groups and for the default group, the recommended total per diem rate is the sum of the following five rate components:

(i) the dietary rate component from (IV)(B)(1)(a);

(ii) the general and administration rate component from (IV)(B)(1)(b);

(iii) the fixed capital asset use fee component from (IV)(B)(1)(c);

(iv) the case mix group's other recipient care per diem rate component by case mix group from (IV)(B)(1)(d); and

(v) the case mix group's total direct care staff rate component for that participating facility as determined in (VI)(F).

(b) For nonparticipating facilities, for each of the 11 TILE case mix groups and for the default group, the recommended total per diem rate is the sum of the following five rate components:

(i) the dietary rate component from (IV)(B)(1)(a);

(ii) the general and administration rate component from (IV)(B)(1)(b);

(iii) the fixed capital asset use fee component from (IV)(B)(1)(c);

(iv) the case mix group's other recipient care per diem rate component by case mix group from (IV)(B)(1)(d); and

(v) the case mix group's direct care staff base rate component as determined in (VI)(E).

STATE Texas DATE REC'D 9-22-03 DATE APPV'D 2-17-04 DATE EFF 9-1-03 HCFA 179	A

(5) Supplemental reimbursement.

(a) Supplemental reimbursement for ventilator-dependent residents. Qualifying residents receive a supplement to the per diem rate specified in (IV)(B)(4) above.

(i) To qualify for supplemental reimbursement, a resident must require artificial ventilation for at least 6 consecutive hours daily and the use must be prescribed by a licensed physician.

(Ii) A ventilator-dependent resource differential case-mix index is calculated, based on time study research data. This resource differential index reflects the difference between direct nursing services for ventilator-dependent residents and services for residents in the most severe heavy-care TILE group. The per diem rate supplement is calculated by multiplying the resource differential case mix index times the per diem average other recipient care rate component, as described in (IV)(B)(1)(d) and by the average direct care staff base rate component as described in (VI)(E) and summing the products.

(iii) The supplemental reimbursement for residents requiring continuous artificial ventilation is 100% of the per diem ventilator rate supplement.

(iv) The supplemental reimbursement for residents not requiring continuous artificial ventilation daily but requiring artificial ventilation for at least 6 consecutive hours daily is 40% of the per diem ventilator rate.

STATE Texas DATE REC'D 9-22-03 DATE APPV'D 2-17-04 DATE EFF 9-1-03 HCFA 179	A

(D) Compliance with Omnibus Budget Reconciliation Acts.

(1) Costs of Compliance with Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). All the costs of compliance with OBRA 1987 are being reported on the cost reports used to set payment rates. It is no longer necessary to provide an add-on to meet these costs. Hence, the payment rates will not require enhancement.

(2) Compliance with Section 4801 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). As explained in (IV)(D)(1), the payment rates will not require enhancement to cover costs of compliance with OBRA 1987. The actual costs of OBRA 1987 appear in provider cost reports used to develop payment rates.

(E) Effective October 1, 1990, any reference in any section of the state plan material to Intermediate Care Facility/Skilled Nursing Facility (ICF/SNF) should be read as Nursing Facility (NF).

(F) For rates effective September 1, 2003 through August 31, 2005, the rates for the dietary rate component from (IV)(B)(1)(a), the general and administration rate component from (IV)(B)(1)(b), the fixed capital asset component from (IV)(B)(1)(c), the other recipient care rate component from (IV)(B)(1)(d), the supplement to per diem rates for qualified ventilator-dependent residents from (IV)(B)(5)(a), the supplement to per diem rates for qualified children with tracheostomies from (IV)(B)(5)(b), and the pediatric care facility rate from (IV)(C) will be equal to the rates in effect August 31, 2003 less 1.75%.

STATE Texas
DATE REC'D 9-22-03
DATE APPV'D 2-17-04
DATE EFF 9-1-03
HCFA 179

A

(VI) Direct Care Staff Rate Component.

(A) Direct care staff cost center. This cost center will include compensation for employee and contract labor Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), medication aides, and nurse aides performing nursing-related duties for Medicaid-contracted beds. For facilities receiving supplemental reimbursement for ventilator-dependent residents or children with tracheostomies, this cost center also includes compensation for employee and contract labor registered Respiratory Therapists and certified Respiratory Therapy Technicians. Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess.

(B) Rate year. The standard rate year begins on the first day of September and ends on the last day of August of the following year.

(C) Enrollment. An initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care staff rate. Participating and nonparticipating facilities may request to modify their enrollment status during any open enrollment period. Enrollment will begin on the first day of July and end on the last day of that same July preceding the rate year for which payments are being determined, unless HHSC notified facilities prior to the first day of July that the open enrollment has been postponed or canceled. Should conditions warrant, additional enrollment periods may be conducted during a rate year. Facilities which do not submit an enrollment contract amendment by the last day of the open enrollment period will continue at the level of participation of the previous year within available funds.

STATE Texas DATE REC'D 9-22-03 DATE APPV'D 2-17-04 DATE EFF 9-1-03 HCFA 179	A

(E) Determination of direct care staff base rate.

(1) Determine the total recipient care costs from the direct care staff cost center in all nursing facilities included in the Texas Nursing Facility Cost Report database used to determine the nursing facility rates in effect on January 1, 2000 (hereinafter referred to as the initial database).

(2) Adjust the total from (VI)(E)(1) to inflate the costs to the prospective rate year as per (III)(D).

(3) Divide the result from (VI)(E)(2) by the total recipient days of service in all facilities in the initial database and multiply the result by 1.07. The result is the average direct care staff rate component for all facilities.

(4) To calculate the direct care staff per diem rate component for all facilities for each of the 11 TILE case mix groups and for the default group, multiply each of the standardized statewide case mix indices associated with the initial database by the average direct care staff rate component from (IV)(E)(3).

(5) The direct care staff per diem rates will remain constant except for adjustments for inflation from (VI)(E)(2). For rates effective September 1, 2003 through August 31, 2005, the direct care staff base rate will be equal to the direct care staff participant base rate in effect on August 31, 2003 less 1.75% .

(G) Staffing requirements for participating facilities. Each participating facility will be required to maintain adjusted LVN equivalent minutes equal to those determined in (VI)(D). Each participating facility's adjusted LVN equivalent minutes maintained during the reporting period will be determined as follows:

(1) Determine unadjusted LVN equivalent minutes maintained. Using facility-specific staffing and spending information, HHSC will determine the unadjusted LVN equivalent minutes maintained by each facility during the reporting period.

(2) Determine adjusted LVN equivalent minutes maintained. Compare the unadjusted LVN equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) to the LVN equivalent minutes required of the facility as determined in (VI)(D). The adjusted LVN equivalent minutes are determined as follows:

(a) If the number of unadjusted LVN equivalent minutes maintained by the facility during the reporting period is greater than or equal to the number of LVN equivalent minutes required of the facility or less than the minimum LVN equivalent minutes required for participation as determined in (VI)(D)(1), the facility's adjusted LVN equivalent minutes maintained is equal to its unadjusted LVN equivalent minutes; or

(b) If the number of unadjusted LVN equivalent minutes maintained by the facility during the reporting period is less than the number of LVN equivalent minutes required of the facility, but greater than or equal to the minimum LVN equivalent minutes required for participation as determined in (VI)(D)(1); the following steps are performed.

(i) Determine what the facility's accrued Medicaid fee-for-service revenue for the reporting period would have been if their staffing requirement had been set at a level consistent with the highest LVN equivalent minutes that the facility actually maintained.

(ii) Determine the facility's adjusted accrued revenue by multiplying the accrued revenue from (VI)(G)(2)(b)(i) by .85.

(iii) Determine the facility's accrued allowable Medicaid fee-for-service direct care staff expenses for the rate year.

(iv) Determine the facility's direct care spending surplus for the reporting period by subtracting the facility's adjusted accrued direct care revenue from (VI)(G)(2)(b)(ii) from the facility's accrued allowable direct care expenses from (VI)(G)(2)(b)(iii).

(v) If the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) is less than or equal to zero, the facility's adjusted LVN equivalent minutes maintained is equal to the unadjusted LVN equivalent minutes maintained as calculated in (VI)(G)(1).

(vi) If the facility's direct Care spending surplus from (VI)(G)(2)(b)(iv) is greater than zero, the adjusted LVN-equivalent minutes maintained by the facility during the reporting period is set equal to the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) divided by the per diem enhancement add-on for one LVN equivalent minute as determined in (VI)(F) plus the unadjusted LVN equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) according to the following formula:

(Direct Care Spending Surplus / Per Diem Enhancement Add-on for One LVN Equivalent Minute) + Unadjusted LVN Equivalent Minutes.

(H) Staffing accountability. Participating facilities will be responsible for maintaining the staffing levels determined in (VI)(D). HHSC will determine the adjusted LVN equivalent minutes maintained by each facility during the reporting period by the method described in (VI)(G).

(1) Participating facilities that fail to maintain staffing at their required level will have their direct care staff rates and staffing requirements adjusted to a level consistent with the highest staffing level that they actually attained and all direct care staff revenues associated with unmet staffing goals will be recouped by HHSC or its designee.

(2) Effective the first day of the rate year immediately following the determination that a facility failed to maintain the required LVN equivalent minutes by four or more adjusted LVN equivalent minutes or that a facility that was required to provide at least four LVN equivalent minutes above its minimum staffing requirement failed to meet its minimum staffing requirement for the reporting period, the facility will have its enrollment in the enhancement program limited to a level consistent with the highest adjusted LVN equivalent minutes that the facility actually attained plus two additional LVN equivalent minutes. If the adjusted level attained is more than two LVN equivalent minutes below the minimum direct care staff requirement for participation, the facility will be precluded from enrollment in the enhancement and will be a nonparticipating facility. These enrollment limitations will remain in effect for the longer of either one full rate year or until the first day of the rate year that begins after funds identified for recoupment from the reporting period are repaid to HHSC or its designee.

(I) Spending requirements for participants. Participating facilities are subject to a direct care staff spending requirement with recoupment calculated as follows:

(1) At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service direct care staff revenues by 0.85.

(2) Accrued allowable Medicaid direct care staff fee-for-service expenses for the rate year will be compared to the spending floor from (VI)(I)(1). HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid direct care staff fee-for-service expenses from facilities whose Medicaid direct care staff spending is less than their spending floor.

(3) Upon request from a parent company, sole member or governmental body that controls more than one nursing facility contract, HHSC will evaluate the contract's compliance with the spending requirements in the aggregate for all contracts that the parent company, sole member or governmental body it controlled at the end of the rate year or at the effective date of the change of ownership or termination of its last nursing facility contract.

(4) At no time will a participating facility's direct care rates after spending recoupment be less than the direct care base rates.

STATE Texas	
DATE REC'D 9-22-03	
DATE APPV'D 2-17-04	A
DATE EFF 9-1-03	
HCFA 179	

(J) Dietary and Fixed Capital Mitigation. Recoupment of funds described in (VI)(I) may be mitigated by high dietary and /or fixed capital expenses as follows.

(1) Calculate dietary cost deficit. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If costs are greater than revenues, the dietary per diem cost deficit will be equal to the difference between accrued, allowable Medicaid dietary per diem costs and accrued Medicaid dietary per diem revenues. If costs are less then revenues, the dietary cost deficit will be equal to zero.

(2) Calculate dietary revenue surplus. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If revenues are greater than costs, the dietary per diem revenue surplus will be equal to the difference between accrued Medicaid dietary per diem revenues and accrued, allowable Medicaid dietary per diem costs. If revenues are less than costs, the dietary revenue surplus will be equal to zero.

(3) Calculate fixed capital cost deficit. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs (i.e., building and building equipment depreciation or lease expense, mortgage interest, land improvements depreciation and leasehold improvements amortization). If costs are greater than revenues, the fixed capital cost per diem deficit will be equal to the difference between accrued allowable Medicaid fixed capital per diem costs and accrued Medicaid fixed capital per diem revenues. If costs are less than revenues, the fixed capital cost deficit will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year. For each facility whose occupancy falls below 85%, an adjustment factor is calculated as follows: adjustment factor = 1.00 – (facility's occupancy rate / .85). This adjustment factor is then multiplied by accrued, allowable Medicaid fixed capital per diem costs, and the result of this calculation is subtracted from accrued, allowable Medicaid fixed capital per diem costs.

STATE Texas	A
DATE REC'D 9-22-03	
DATE APP'D 2-17-04	
DATE EFF 9-1-03	
HCFA 179	

(4) Calculated fixed capital revenue surplus. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs as defined in (VI)(J)(c). If revenues are greater than costs, the fixed capital revenue per diem surplus will be equal to the difference between accrued Medicaid fixed capital per diem revenues and accrued, allowable Medicaid fixed capital per diem costs. If revenues are less than costs, the fixed capital revenue surplus will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year. For each facility whose occupancy falls below 85%, an adjustment factor is calculated as follows: adjustment factor = 1.00 – (facility's occupancy rate / .85). This adjustment factor is then multiplied by accrued, allowable Medicaid fixed capital per diem costs, and the result of this calculation is subtracted from accrued, allowable Medicaid fixed capital per diem costs.

(5) Facilities with a dietary per diem cost deficit will have their dietary per diem cost deficit reduced by their fixed capital per diem revenue surplus, if any. Any remaining dietary per diem cost deficit will be capped at $2.00 per diem.

(6) Facilities with a fixed capital cost per diem deficit will have their fixed capital cost per diem deficit reduced by their dietary revenue per diem surplus, if any. Any remaining fixed capital per diem cost deficit will be capped at $2.00 per diem.

(7) Each facility's recoupment, as calculated in (VI)(I), will be reduced by the sum of that facility's dietary per diem cost deficit as calculated in (VI)(J)(5) and its fixed capital per diem cost deficit as calculated in (VI)(J)(6).

STATE TEXAS	A
DATE REC'D 9-22-03	
DATE APPV'D 2-17-04	
DATE EFF 9-1-03	
HCFA 179	

(K) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes NF nursing care to a Medicaid recipient, DHS makes payment to the hospital using the same procedures, the same case-mix methodology and the same TILE rates that HHSC authorizes for reimbursing NFs which are not participating in the enhanced direct care staff rate. These hospitals are not subject to the staffing and spending requirements.

(L) Reinvestment. HHSC will reinvest recouped funds in the enhanced direct care staff rate program.

(1) Identifying qualifying facilities. Facilities meeting the following criteria during the most recent completed reporting period are qualifying facilities for reinvestment purposes.

(a) The facility was a participant in the enhanced direct care staff rate.

(b) The facility's unadjusted LVN equivalent minutes as determined in (VI)(G)(1) were greater than the number of LVN minutes required of the facility as determined in (VI)(D).

(c) The facility met its spending requirement as determined in (VI)(I).

(d) An acceptable Staffing and Compensation Report was received at least 30 days prior to the date distribution of funds was determined.

(e) The DHS contract that was in effect for the facility during the reinvestment reporting period is still in effect as an active contract when reinvestment is determined or, in cases where a change of ownership has occurred, DHS has approved a Successor Liability Agreement between the contract in effect during the reinvestment reporting period and the contract in effect when reinvestment is determined.

(2) Distribution of available reinvestment funds. Available funds are distributed as described below.

(a) HHSC determines units of service provided during the most recent completed reporting period by qualifying facilities achieving, with unadjusted LVN-equivalent minutes as determined in (VI)(G)(1), each enhancement option above the enhancement option awarded to the facility during the reporting period and multiplies this number by the rate add-on associated with that enhancement in effect during the reporting period.

(b) HHSC compares the sum of the products from (VI)(L)(2)(a) to funds available for reinvestment.

(i) If the product is less than or equal to available funds, all achieved enhancements for qualifying facilities are retroactively awarded for the reporting period.

(ii) If the product is greater than available funds, retroactive enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until achieved enhancements are granted within available funds.

(3) All retroactive enhancements are subject to spending requirements detailed in (VI)(I). Revenue from retroactive enhancements is not eligible for mitigation of spending recoupment as described in (VI)(J).

(4) Retroactively awarded enhancements do not qualify as pre-existing enhancements for enrollment purposes.

(5) Notification of reinvested enhancements. Qualifying facilities are notified in a manner determined by HHSC, as to the award of reinvest enhancements.

(K) Failure to Submit Staffing and Compensation Report. Facilities that do not submit a Staffing and Compensation Report completed in accordance with all applicable rules and instructions within 60 days of the due date will become nonparticipating facilities retroactive to the first day of the reporting period and will be subject to an immediate recoupment of funds related to participation paid to the facility for services provided during the reporting period in question. These facilities will remain nonparticipating facilities and recouped funds will not be restored until an acceptable report is received. Funds identified for recoupment based on the report will be deducted from recouped funds before the recouped funds are restored.

STATE	TEXAS
DATE REC'D	9-22-03
DATE APP'VD	2-17-04
DATE EFF	9-1-03
HCFA 179	
	A